

ABOUT MEDICAL DECISIONS REGARDING ADMISSION OF PATIENTS TO CRITICAL CARE UNITS DURING PANDEMIC: ETHICAL CONSIDERATIONS

Background	<ul style="list-style-type: none"> An extraordinary worldwide pandemic results in acceleration of care temporality and loss of balance between needs and resources regarding ICU beds. Caregivers are thus led to urgently make difficult decisions.
Risks	<ul style="list-style-type: none"> Too strained temporality could threaten the time needed to deliberate before making a decision, and the time needed to make that decision acceptable both to relatives and caregivers. Distorting ethics to this exceptional situation could give way to arbitrary through abandon of the very values of care: respect for dignity and autonomy, beneficence and non-maleficence, and quality of care for all. A logic of efficiency could exclude the most vulnerable ones. Unfair resource allocation could impair mobilisation of assets for non COVID critically ill patients, and for non critically ill patients (such as patients suffering from evolutive cancers).

MAKING A DECISION

The situation must not lead to abandoning principles which usually apply when caregivers have to make decisions to withhold or withdraw treatments. Aim is to preserve medical decisions based on deliberation, yet accepting to allocate resources to patients for whom interventions have the highest probability of success. Existing documents regarding treatment withholding/withdrawal thus do not need to be modified. However, practical implementation of the decision process must adjust to pandemic-related time and organisation constraints. Decision criteria can hardly be generalised. They need to be adjusted to local health situation and to its evolution with time. These decision principles must be complied with for all patients irrespective of their COVID status.

1. ANTICIPATION	Anticipate decisions to avoid urgency, thereby offering the time needed to deliberate and to mull over resulting decisions.
2. PATIENT'S WISHES	Collect patient's wishes, either directly expressed, written in advance directives or testified by next of kin.
3. COLLEGIALLY	Although the physician in charge is ultimately responsible for decision, deliberation requires at least one other physician to provide their reasoned opinion and at least one member of caregiving staff to express their view.
4. DECISION ELEMENTS	<p>Previous condition: age, comorbidities, frailty (CFS), neurocognitive disorders.</p> <p>Current severity: $O_2 > 6L/min$ or respiratory failure, Glasgow < 12, sBP $< 90mmHg$, SOFA score.</p> <p>Worsening rate for both previous and current condition.</p> <p>Iterative and regular assessment of response to ongoing treatments.</p>
5. TRANSPARENCY	<p>Track decisions and their justification in medical record.</p> <p>Inform next of kins about decisions made</p>

ENSURING PATIENT COMFORT

- Assess comfort: pain, anxiety, agitation, dyspnoea, bronchial obstruction, asphyxia.
- Give appropriate analgesia and sedation. Anticipate needs.
- When applicable, comply with patient's right to be given deep and continuous sedation resulting in impaired consciousness and continued until death.
- Resort to palliative care teams.

MAINTAINING COMMUNICATION WITH NEXT OF KINS

- Provide them with regular, intelligible, loyal and sincere information. Favour video communication and consider making exceptions to visit restrictions depending on situation, in compliance with protection measures.
- Mobilise assets to offer them accompaniment and link despite physical distancing.

PROTECTING CAREGIVERS

- From risk of contamination, ensuring they are granted access to appropriate protective equipment.
- From risk of burn-out, through clear and action-centred leadership, benevolence in management, adequate training, sufficient recovery time, etc.
- From uncertainty in decision-making, which is made even greater by the lack of knowledge about this pandemic in current scientific literature
- Promote resorting to psychological support teams during and after crisis.

ADAPTING CONTINUOUSLY

- To local, regional and national health situation, and to unique situation of the patient
- To new knowledge, especially regarding prognostic factors, and to feedback from caregivers.
- Prepare for the time when strictly medical criteria become insufficient to triage patient inflow: who will decide, and based on which criteria?
- Seek help or advice from ethical support teams that have been implemented all over the country.



DECISION AID FOR PATIENT ORIENTATION DURING COVID-19 PANDEMIC

REDACTOR Date: Time: Name Téléphone	PATIENT Surame First name DOB / / Patient location upon redaction
LOCAL HEALTH SITUATION Available resources / critical care • yes • no Available resources / medical ward • yes • no Possible transfer • yes • no If no : • non transportable • system saturation	NEXT OF KIN : reached • yes • no = declared trusted person • yes • no Name Relationship Telephone
PATIENT WISHES known regarding end of life and/or admission to critical care unit: • yes • no If yes: • currently expressed by patient • advance directives • declared trusted person or next of kin If yes, explicit wishes: • no ICU • no invasive mechanical ventilation • other:	
PREVIOUS PATIENT CONDITION Age: Clinical frailty score CFS (1 to 9) : Comorbidities: • yes • no If yes • Non severe stabilised comorbidities • 1 severe comorbidity • >1 severe comorbidity Neurocognitive disorders: • yes • no If yes • Moderate • Severe • Very severe Fast worsening rate • yes • no	CURRENT CLINICAL SEVERITY Current main diagnosis : Current main organ failure • Respiratory. O ₂ >6L/min or respiratory distress • yes • no • Hemodynamic. sBP<90mmHg • yes • no • Neurological. Glasgow <12 • yes • no SOFA score .../20 Fast worsening rate • yes • no
PATIENT COMFORT Pain • yes • no Anxiety • yes • no Agitation • yes • no Dyspnoea • yes • no Bronchial obstruction • yes • no Asphyxia • yes • no	PALLIATIVE CARE TEAM Called • yes • no Phone # if needed : Anticipated prescription : • yes • no
COLLEGIALLY Physician in charge: External consultant physician: Contributing caregiver(s) within team:	ORIENTATION DECISION • ICU admission possible • without restriction • with restriction • No endotracheal intubation, no invasive ventilation • No CPR • No vasopressors • No renal replacement therapy • Other: • No ICU admission • Curative care in ward • Palliative care in ward
Next of kin informed • yes • no Tracked decision • yes • no	REASONS FOR DECISION